

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/31/2013	
NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00134982 and Complaint IN00136291 completed on 09/24/2013.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00138643.</p> <p>Complaints IN00134982 and IN00136291 corrected.</p> <p>Survey dates: October 30 & 31, 2013</p> <p>Facility number: 000032 Provider number: 155077 AIM number: 100273330</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: SNF: 14 SNF/NF: 103 Total: 117</p> <p>Census payor type: Medicare: 12 Medicaid: 96 Other: 9 Total: 117</p> <p>Sample: 3</p> <p>Lakeview Manor, Inc. was found to be compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the PSR to Complaint IN00134982 and Complaint IN00136291.</p> <p>Quality review completed on 11/01/2013 by</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/31/2013
NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	Continued From page 1 Brenda Marshall Nunan, RN.	{F 000}			